KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Electronic Documents Policy

This policy document constitutes the explicit, written permission of Kaiser Foundation Health Plan, Inc., (Health Plan) for the Purchaser to use the accompanying Health Plan Enrollment and Member electronic documents under the following conditions:

These electronic documents must be used as provided, without additions, deletions, or other modifications.

These electronic documents are being provided in English. Translation of these documents by any person/organization other than by Health Plan (or certified translation agencies authorized by Health Plan) is prohibited. Please contact your Health Plan account representative to learn which documents are available in other languages.

These electronic documents may be posted to Purchaser Web sites.

Health Plan will provide updated versions of these electronic documents if there are substantive language changes. Purchasers must transfer the updated versions to their sites as soon as reasonably possible, but not later than 30 days after receipt of an updated document.

The Disclosure Form (DF) is subject to change. Health Plan will provide substantive DF language changes electronically to Purchasers. It is the Purchaser's responsibility to ensure that all changes are provided to employees. All electronic DF documents include a footnote containing an original issuance date to ensure accurate tracking.

If you have questions about our Electronic Documents Policy, or questions about a specific request for an electronic document, please contact your account representative for assistance.

Kaiser Foundation Health Plan, Inc.
California Division

624087.21.1.S006408849

Disclosure Form Part One — Principal Benefits for Kaiser Permanente Traditional Plan (1/1/05—12/31/05)

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary for authorized referrals, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services described in the *Evidence of Coverage*

Annual Out-of-Pocket Maximum	
For one Member	$1,500 per calendar year
For an entire Family Unit	$3,000 per calendar year
Deductible or Lifetime Maximum	**None**
Coordination of Benefits	**Included**
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and urgent care appointments)	$30 per visit
Routine physical exams	$30 per visit
Well-child preventive care visits to age 2	$5 per visit
Family planning visits	$30 per visit
Scheduled prenatal care and first postpartum visit	$5 per visit
Eye exams	$30 per visit
Hearing tests	$30 per visit
Physical, occupational, and speech therapy visits	$30 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$30 per procedure
Allergy injection visits	No charge
Allergy testing visits	$30 per visit
Immunizations	No charge
X-rays and lab tests	No charge
Health education	$30 per individual visit No charge for group visits
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$500 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit (waived if you are held for observation in a hospital unit outside the Emergency Department or if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies:	
Generic items	$15 for up to a 100-day supply
Brand name items	$30 for up to a 100-day supply

(CONTINUED)

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our DME formulary	No charge

Mental Health Services	You Pay
Inpatient psychiatric care (up to 45 days per calendar year)	$500 per admission
Outpatient visits:	
Up to a total of 20 individual and/or group therapy visits per calendar year	$30 per individual therapy visit $15 per group therapy visit
Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	$15 per group therapy visit

Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

Chemical Dependency Services	You Pay
Inpatient detoxification	$500 per admission
Outpatient individual therapy visits	$30 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	You Pay
Home health care (up to 100 two-hour visits per calendar year)	No charge

Other	You Pay
Eyewear purchased from Plan optical sales offices every 24 months	$150 Allowance
Hearing aid(s) every 36 months	$500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

This is a brief summary of the most frequently asked about benefits and their Copayments and Coinsurance. This chart does not describe benefits and it does not list all benefits, Copayments, and Coinsurance. Please refer to the *Evidence of Coverage* to learn about coverage (including exclusions and limitations) and other benefits, Copayments, and Coinsurance that are not included in this summary. Note: We cover benefits in accord with applicable law (for example, diabetes supplies).

This Disclosure Form summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage.

Your Health Plan Coverage

Disclosure Form—Part Two for Kaiser Permanente Traditional Plan

Kaiser Foundation Health Plan, Inc.
Southern California Region

KAISER PERMANENTE®

PDF 0149-0513-01-r03 8/04

Your Health Plan Coverage

Table of contents

Member Service Call Center
1-800-464-4000
(1-800-777-1370 TTY)
7 a.m. to 7 p.m.
Seven days a week
(except holidays)

PDF 0149-0513-01-r03 8/04

Your Health Plan Coverage

Introduction

Welcome to Kaiser Permanente

When you join Kaiser Permanente, you get a health plan that's dedicated to your total well-being.

Our preventive care programs and health education classes offer you and your family great ways to protect and improve your health. You get a wealth of information online with **kaiserpermanente.org**. Save time in requesting routine appointments and prescription refills. Use the extensive health and drug encyclopedias to learn more about your health. Find Kaiser Permanente medical facilities and providers close to home or work.

When you need medical care, we've got you covered. You can have a personal physician who understands your lifestyle. You can often take care of many health needs at one place, in one trip—from office visits to lab work, pharmacy, and X-rays. Most of our facilities provide same-day urgent care appointments, and many have evening and weekend appointments. And, you're not limited to receiving care from just one facility; you pick the Plan Facility that's most convenient for you. If you need specialty care, you have access to a wide array of medical specialties. You can even self-refer to selected specialties. And you can depend on the security of emergency coverage anywhere in the world.

We are committed to investing first and foremost in your health. From routine checkups to online services to emergency care, you can count on us to help you stay healthy.

About this booklet

This *Disclosure Form* summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage. **Please read the following information so that you will know from whom or what group of providers you may obtain health care. Also, you should read this *Disclosure Form* and the *Evidence of Coverage* carefully if you have special health care needs.**

Please see *Your Benefits (Disclosure Form—Part One)* for information about Copayments, Coinsurance, Deductibles, and benefits. If you have questions about benefits, please call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**.

Capitalized terms have special meaning in this *Disclosure Form,* as described in the "Definitions" section at the end of this booklet.

Evidence of Coverage: To obtain an *Evidence of Coverage*, please contact your group benefits administrator to request one. Your *Evidence of Coverage* provides details about the terms and conditions of your coverage, including exclusions and limitations. Also, you have the right to review one prior to enrollment. This *Disclosure Form* is only a summary.

Note: State law requires *Disclosure Form* documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion.

PDF 0149-0513-01-r03 8/04

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**, to ensure that you can obtain the health care services that you need."

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

How to obtain care

Our Members receive medical care from Plan Providers (physicians, registered nurses, nurse practitioners, and other medical professionals) at Plan Facilities except as described in this *Disclosure Form* or the *Evidence of Coverage* about:

- Getting a referral
- Visiting other Regions
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care
- Emergency ambulance Services

For Plan Facility locations, please refer to the enclosed facility listing, *Your Guidebook to Kaiser Permanente Services (Your Guidebook),* our Web site, **kaiserpermanente.org**, or your local telephone book under "Kaiser Permanente."

Emergency Care and Post-stabilization Care

Emergency Care. If you have an Emergency Medical Condition, call **911** or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care from Plan Providers and non–Plan Providers anywhere in the world.

An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - ♦ serious jeopardy to your health
  - ♦ serious impairment to your bodily functions
  - ♦ serious dysfunction of any bodily organ or part
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child

Note: Emergency Care is available at Plan Hospital Emergency Departments. For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department, but only if it is reasonable to do so, considering your condition or symptoms. Please refer to the enclosed facility listing or *Your Guidebook* for Plan Hospital Emergency Department locations in your area.

PDF 0149-0513-01-r03 8/04

Post-stabilization Care. Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-stabilization Care only if a Plan Provider provides it or if we authorize your receiving the care from a non–Plan Provider.

To request authorization to receive Post-stabilization Care from a non–Plan Provider, you must call us at **1-800-225-8883** *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). Be sure to ask the non–Plan Provider to tell you what care (including any transportation) we have authorized since we do not cover unauthorized Post-stabilization Care or related transportation provided by non–Plan Providers.

Please refer to your *Evidence of Coverage* for coverage information, exclusions, and limitations.

Urgent care

When you are sick or injured, you may have an urgent care need. An urgent care need is one that requires prompt medical attention, but is not an Emergency Medical Condition. If you think you may need urgent care, call the appropriate appointment or advice nurse telephone number at a Plan Facility. Please refer to *Your Guidebook* for advice nurse and Plan Facility telephone numbers.

Out-of-Area Urgent Care. If you are temporarily outside our Service Area and have an urgent care need due to an unforeseen illness, injury, or complication of an existing condition (including pregnancy), we cover the Medically Necessary Services you receive from a non–Plan Provider if we find that the Services were necessary to prevent serious deterioration of your (or your unborn child's) health and the Services could not be delayed until you returned to our Service Area.

Your identification card

Each Member's Health Plan ID card has a Medical Record Number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. Your Medical Record Number is used to identify your medical records and membership information. Your Medical Record Number should never change. Please let us know if we ever inadvertently issue you more than one Medical Record Number, or if you need to replace your ID card, by calling our Member Service Call Center.

If you need to get care before you receive your ID card, please ask your group benefits administrator for your group (purchaser) number and the date your coverage became effective. This information will be helpful if you need care prior to receiving your ID card.

PDF 0149-0513-01-r03 8/04

Plan Facilities and *Your Guidebook*

At most of our Plan Facilities, you can usually receive all the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you. For facility locations, please refer to the enclosed facility listing or call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY).**

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Care is available from Plan Hospital Emergency Departments as described in *Your Guidebook to Kaiser Permanente Services (Your Guidebook)*
- Same-day urgent care appointments are available at many locations
- Many Plan Medical Offices have evening and weekend appointments

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook*. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. *Your Guidebook* also explains how to use our Services and make appointments, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities.

Your Guidebook is subject to change and periodically updated. Also, we will mail you *Your Guidebook* after you've enrolled. If you do not receive a copy or need another copy, call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**, 7 a.m. to 7 p.m., seven days a week. You can also download a copy from our Web site, **kaiserpermanente.org**.

Your primary care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. Also, women can select any available primary care Plan Physician from obstetrics/gynecology. You can change your primary care Plan Physician for any reason. To learn how to select a primary care Plan Physician, please call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**. You can find a directory of our Plan Physicians on our Web site at **kaiserpermanente.org**.

Special note about Coachella Valley and western Ventura County

Subscribers residing in Coachella Valley and western Ventura County are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. In these areas, Plan Providers (except for Plan Pharmacies that are owned and operated by Kaiser Permanente)

PDF 0149-0513-01-r03 8/04

are referred to as "Affiliated Providers," for example "Affiliated Physicians" and "Affiliated Hospitals." Please refer to our Service Area description in the "Definitions" section for the ZIP codes that are in these two areas.

Your primary care Affiliated Physician will provide or arrange your care in these areas, including Services from other Affiliated Providers, such as specialty Affiliated Physicians. **For Services from Affiliated Providers to be covered, your primary care Affiliated Physician must prescribe the care or authorize the referral**, except that women can get annual mammograms and visits to their obstetrics/gynecology Affiliated Physician without a referral from a primary care Affiliated Physician. Also, you may receive care from Plan Providers outside Coachella Valley and western Ventura County without a referral from your primary care Affiliated Physician. Some care requires a referral from a primary care Plan Physician, but the Plan Physician does not have to be an Affiliated Physician; for more details see "Referrals to Plan Providers" in the "Getting a referral" section.

We will send you, the Subscriber, a letter explaining how to select a primary care Affiliated Physician. If you don't select a primary care Affiliated Physician, we will assign one. Dependents may select a different primary care Affiliated Physician from the Subscriber's by calling our Member Service Call Center. You may change your primary care Affiliated Physician once a month. If you need care before we have confirmed your primary care Affiliated Physician, please call our Member Service Call Center for assistance. To learn about Affiliated Providers, please refer to *Your Guidebook*.

If the Subscriber in your Family Unit does not live in Coachella Valley or western Ventura County, you may receive covered care from Affiliated Providers in these areas even if you haven't chosen a primary care Affiliated Physician.

Getting a referral

Referrals to Plan Providers

Primary care Plan Physicians provide primary medical care, including pediatric care and obstetrics/gynecology care. Plan specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician will refer you to a Plan specialist when appropriate. You don't need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, obstetrics/gynecology, family planning, family medicine, pediatrics, optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that don't require a referral. Also, please refer to "Special note about Coachella Valley and western Ventura County" for additional requirements that apply when a Subscriber lives in these areas.

PDF 0149-0513-01-r03 8/04

Medical Group authorization procedure for certain referrals

The following Services require prior authorization by Medical Group for the Services to be covered:

- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to Medical Group that you be referred to a non–Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider
- **Bariatric surgery.** If your Plan Physician makes a written referral for bariatric surgery, Medical Group's regional bariatric medical director or his or her designee will authorize the Service if he or she determines that it is Medically Necessary
- **Durable medical equipment (DME).** If your Plan Physician prescribes DME, he or she will submit a written referral to the Plan Hospital's DME coordinator, who will authorize the DME if he or she determines that your DME coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our DME formulary guidelines, then the DME coordinator will contact the Plan Physician for additional information. If the DME request still doesn't appear to meet our DME formulary guidelines, it will be submitted to Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our DME formulary, please refer to the *Evidence of Coverage*
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that the item is listed on our formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to the *Evidence of Coverage*
- **Transplants.** If your Plan Physician makes a written referral for a transplant, Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary

PDF 0149-0513-01-r03 8/04

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. This description is only a brief summary of the authorization procedure. For more information, please refer to the *Evidence of Coverage* or call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**.

Second opinions

If you request a second opinion, it will be provided to you by an appropriately qualified medical professional. You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Provider. For more information, please refer to the *Evidence of Coverage*.

Provider reimbursement

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please ask your Plan Physician or call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**.

Your costs

Copayments and Coinsurance

Copayments or Coinsurance are due when you receive the Service. However, before you can schedule an elective infertility procedure, you must pay the Copayment or Coinsurance for the procedure along with any past-due, infertility-related Copayments and Coinsurance. For items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it).

Note: If we bill you for a Copayment or Coinsurance. we will add $13.50 billing charge and send you a bill for the entire amount. This $13.50 billing charge will not count toward the annual out-of-pocket maximum.

Copayments and Coinsurance are listed in *Your Benefits* (*Disclosure Form—Part One*).

Deductibles

If your coverage includes Deductibles, we will not cover certain Services until you meet a Deductible each calendar year. The only payments that count toward a Deductible are those you make for Services that are subject to the Deductible, but only if the Service would otherwise be covered. Please refer to the *Your Benefits* (*Disclosure Form—Part One*) to learn if your coverage is subject to a Deductible.

PDF 0149-0513-01-r03 8/04

Annual out-of-pocket maximum

There is a limit (specified in the *Disclosure Form—Part One*) to the total amount you must pay in a calendar year for certain Services, which are listed in your *Evidence of Coverage*. When you pay for these Services, ask for and keep the receipt. When the receipts add up to the annual out-of-pocket maximum, please call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)** to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you do not have to pay any more Copayments or Coinsurance for the specified Services through the end of the calendar year.

Prepayment of Dues

Your group is responsible for paying Dues. If you are responsible for any contribution to the Dues, your group will tell you the amount and how to pay your group (through payroll deduction, for example).

Your liability for payment

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of noncovered Services or of Services you obtain from non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will cover the care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. In some cases, you may be eligible for a longer period of covered care from a terminated provider in accord with applicable law. Please refer to "Completion of Services from non–Plan Providers" in the "Miscellaneous notices" section for more information.

Reimbursement for non-Plan Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a non–Plan Provider

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a non–Plan Provider, you must file a claim if you want us to pay for the Services. This is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)** or **1-800-390-3510**, 7 a.m. to 7 p.m., seven days a week
- If you have paid for the Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the non–Plan Provider.
- To request that a non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the non–Plan Provider. If the non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the non–Plan Provider, please call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)** or **1-800-390-3510**, 7 a.m. to 7 p.m., seven days a week, to confirm that we have received everything we need

PDF 0149-0513-01-r03 8/04

- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled

Please refer to your *Evidence of Coverage* for additional instructions, coverage information, exclusions, limitations, and dispute resolution for denied claims.

Termination of benefits

Your Group is required to inform the Subscriber of the date your membership terminates except as otherwise noted. You will be billed as a non-Member for any Services you receive after your membership terminates.

Membership will cease for you and your Dependents if any of the following occurs:

- The contract between your group and Kaiser Permanente is terminated for any reason
- You are no longer eligible for group coverage as described in your *Evidence of Coverage*
- You commit one of the following acts, we may terminate your membership immediately by sending written notice to the Subscriber; termination will be effective on the date we send the notice, and you will not be allowed to enroll in Health Plan in the future:
  - your behavior threatens the safety of Plan personnel, or of any person or property at a Plan Facility
  - you commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
  - you knowingly commit fraud in connection with membership, Health Plan, or a Plan Provider
- Your Group fails to pay us the appropriate Dues for your Family Unit
- You fail to pay any amount you owe Health Plan or a Plan Provider (for example, if you fail to pay Copayments and Coinsurance). We will send written notice of the termination to the Subscriber at least 15 days before the termination date. Persons whose memberships are terminated for nonpayment of other charges may not enroll in Health Plan unless all amounts owed have been paid, and then, only if we approve the enrollment

Please refer to the *Evidence of Coverage* for more information.

PDF 0149-0513-01-r03 8/04

Continuation of membership

Continuation of group coverage

You may be able to continue your group coverage for a limited time after you would otherwise lose eligibility, if required by law under COBRA or Cal-COBRA. Please refer to the *Evidence of Coverage* for more information.

If you are called to active duty in the uniformed services, you may be able to continue your coverage for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Please contact your group if you want to know how to elect USERRA coverage and how much you must pay your group.

Converting to an individual plan

You may be eligible to convert to our nongroup Individual (Conversion) Plan if you no longer meet the eligibility requirements described in the *Evidence of Coverage*, or if you enroll in COBRA, Cal-COBRA, or USERRA continuation coverage and then lose eligibility for that coverage. You must apply for conversion of membership within 63 days after your group coverage ends.

For information about converting your membership or about other individual plans, please refer to the *Evidence of Coverage*, or call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**.

Getting assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your primary care Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you seven days a week (except holidays), from 7 a.m. to 7 p.m., at **1-800-464-4000 (1-800-777-1370 TTY)**. For your convenience, you can also contact us through our Web site at **kaiserpermanente.org**.

Member Service representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim.

PDF 0149-0513-01-r03 8/04

Your Health Plan Coverage

Dispute resolution and binding arbitration

Member Service representatives at Plan Facilities or our Member Service Call Center can help you with unresolved issues. They can also help you file a grievance orally or in writing. You can also submit a grievance electronically at **kaiserpermanente.org**.

Independent medical review is available if you believe that we improperly denied, modified, or delayed Services, and that either (1) our denial was based on a finding that the requested Services or payment for Services were not Medically Necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you should file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care at **1-888-HMO-2219** for assistance.

Except for Small Claims Court cases and, if your group must comply with Employee Retirement Income Security Act (ERISA), certain benefit-related disputes, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, Services, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

This is a brief summary of dispute resolution options. Please refer to your *Evidence of Coverage* for more information, including the complete arbitration provision.

Renewal provisions

Your group is responsible for informing you when its contract with Kaiser Permanente is changed or terminated. The contract generally changes each year, or sooner if required by law.

Principal exclusions, limitations, and reductions of benefits

Exclusions

The following are the principal exclusions from coverage. See your *Evidence of Coverage* for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions that apply only to a particular Service are listed in the description of that Service in the benefit description in your *Evidence of Coverage*.

- Care in a licensed intermediate care facility, except for covered hospice care
- Chiropractic Services
- Conception by artificial means
- Cosmetic Services except for Services covered under "Reconstructive Surgery" in the *Evidence of Coverage*

PDF 0149-0513-01-r03 8/04

- Custodial care, except for covered hospice care
- Dental care and dental X-rays
- Experimental or investigational Services, except as required by law for certain cancer clinical trials
- Hearing aids unless otherwise stated in your *Evidence of Coverage*
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation unless a Plan Physician determines that the Services are Medically Necessary
- Routine foot care Services that are not Medically Necessary
- Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
- Services related to a noncovered Service except that this exclusion does not apply to Services we would otherwise cover to treat complications of the noncovered Service
- Sexual reassignment surgery
- Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development unless Medically Necessary
- Travel and lodging expenses
- Treatment of hair loss or growth

Limitations

We will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care and Post-stabilization Care" in the "How to obtain care" section and we will provide coverage as described in that section.

Reductions

If you become ill or injured through the fault of a third party and you collect any money from the third party or from his or her insurance company, you must reimburse us for any Services we covered for that injury or illness. Alternatively, we may file a claim against the third party on our own behalf for the value of the Services we covered for that injury or illness.

Please refer to your *Evidence of Coverage* for additional information and other reductions (for example, surrogacy arrangements and workers' compensation).

PDF 0149-0513-01-r03 8/04

To become a Member

We look forward to welcoming you as a Kaiser Permanente Member. If you are eligible to enroll, simply return a completed enrollment application to your group benefits administrator. Be sure to ask your benefits administrator for your group (purchaser) number and the date when your coverage becomes effective. You can begin using our Services on your effective date of coverage. Again, if you have any questions about Kaiser Permanente, please call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)** or you can refer to the *Evidence of Coverage* for details about eligibility requirements.

Miscellaneous notices

Completion of Services from non–Plan Providers

New Member. If you are currently receiving Services from a non–Plan Provider in one of the cases listed below under "Eligibility" and your enrollment with us will end your prior plan's coverage of the provider's Services, you may be eligible for limited coverage of that non–Plan Provider's Services.

Terminated provider. If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility. The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- We may cover Services for serious chronic conditions until the earlier of (i) 12 months from your membership effective date if you are a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the first day when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - ♦ it persists without full cure
  - ♦ it worsens over an extended period of time
  - ♦ it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness

PDF 0149-0513-01-r03 8/04

- Care for children under age three. We may cover completion of these Services until the earlier of (i) 12 months from the child's membership effective date if the child is a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your membership effective date if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Service
- You are receiving Services in one of the cases listed above from a non–Plan Provider on your membership effective date if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area
- The Services to be provided to you would be covered Services under your *Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your membership effective date if you are a new Member, or from the termination date of the Plan Provider

The Deductibles, Copayments and Coinsurance for completion of Services are the same as those required for Services provided by a Plan Provider as described in the *Evidence of Coverage*. **For more information about this provision and to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Call Center.**

Drug formulary

Our drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available. If you would like to request a copy of our drug formulary, please call our Member Service Call Center. The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

PDF 0149-0513-01-r03 8/04

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file a grievance as described in the *Evidence of Coverage*. Also, our formulary guidelines may require you to participate in a Plan–approved behavioral intervention program for specific conditions, and you may be required to pay for the program.

Please refer to *Your Benefits (Disclosure Form—Part One*) to learn if you have coverage for outpatient prescription drugs.

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, **1-800-434-0222 (1-800-722-3140 TTY)**, for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Nonfederally qualified

This plan is a nonfederally qualified plan.

Privacy practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our Web site at kaiserpermanente.org.

PDF 0149-0513-01-r03 8/04

Special note about Medicare

The information contained in this booklet is not applicable for most Medicare beneficiaries. Please check with your group benefits administrator to determine the correct *Disclosure Form* that applies to you if you are eligible for Medicare, and to learn whether you are eligible to enroll in Kaiser Permanente Senior Advantage.

Definitions

Allowance: A credit that you can use toward the purchase price of an item. If the price of the item(s) you select exceeds the allowance, you will pay the difference.

Charges: Charges means the following:

- For Services provided by Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospital charges for Services provided to Members
- For Services for which a provider (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services (or, if Kaiser Permanente subtracts a Copayment, Coinsurance, or Deductible from its payment, the amount Kaiser Permanente would have paid if it did not subtract the Copayment, Coinsurance, or Deductible)

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form—Part One*). For the complete list of Copayments and Coinsurance, please refer to your *Evidence of Coverage*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form—Part One*). For the complete list of Copayments and Coinsurance, please refer to your *Evidence of Coverage*.

PDF 0149-0513-01-r03 8/04

Deductible: The Deductible is an amount you must pay in a calendar year for certain Services before we will cover those Services in that calendar year. Any Deductible amounts are listed in *Your Benefits (Disclosure Form—Part One)*.

Dependent: A Member who meets the eligibility requirements as a Dependent as described in the *Evidence of Coverage*.

Dues: Periodic membership charges paid by group.

Emergency Care: Emergency Care is:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law)
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the *Evidence of Coverage*

Emergency Medical Condition: An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - ♦ serious jeopardy to your health
  - ♦ serious impairment to your bodily functions
  - ♦ serious dysfunction of any bodily organ or part
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *Disclosure Form* sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and Medical Group.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Member: A person who is eligible and enrolled, and for whom we have received applicable Dues. This *Disclosure Form* sometimes refers to a Member as "you."

PDF 0149-0513-01-r03 8/04

Out-of-Area Urgent Care: An urgent care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services you receive from a non–Plan Provider for an unforeseen illness, injury, or complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- The Services are necessary to prevent serious deterioration of your (or your unborn child's) health
- Treatment cannot be delayed until you return to our Service Area

Plan: Kaiser Permanente.

Plan Facility: Any facility listed in the enclosed facility listing or one of the *Guidebooks* for our Service Area, except that Plan Facilities are subject to change at any time without notice. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

Plan Hospital: Any hospital listed in the enclosed facility listing or one of the *Guidebooks* for our Service Area, except that Plan Hospitals are subject to change at any time without notice. If you have any questions about the current locations of Plan Hospitals, please call our Member Service Call Center.

Plan Medical Office: Any medical office listed in the enclosed facility listing or one of the *Guidebooks* for our Service Area, except that Plan Medical Offices are subject to change at any time without notice. If you have any questions about the current locations of Plan Medical Offices, please call our Member Service Call Center.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to the enclosed facility listing or *Your Guidebook* for a list of Plan Pharmacies in your area, except that Plan Pharmacies are subject to change at any time without notice. If you have any questions about the current locations of Plan Pharmacies, please call our Member Service Call Center.

Plan Physician: Any licensed physician who is a partner or an employee of Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician, Medical Group, Plan Pharmacy, or other health care provider that we designate as a Plan Provider.

Post-stabilization Care: Post-stabilization Care is the Medically Necessary Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of Northern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center at **1-800-464-4000 (1-800-777-1370 TTY)**.

PDF 0149-0513-01-r03 8/04

Your Health Plan Coverage

Service Area: The following counties are entirely inside our Service Area: Orange and Los Angeles (except ZIP code 90704). Portions of the following counties, as indicated by the ZIP codes below, are also inside our Service Area:

- **Imperial:** 92274-75*
- **Kern:** 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- **Riverside:** 91752, 92201-03*, 92210-11*, 92220, 92223, 92230*, 92234-36*, 92240-41*, 92247-48*, 92253-55*, 92258*, 92260-64*, 92270*, 92274*, 92276*, 92282*, 92292*, 92320, 92324, 92373, 92399, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92599, 92860, 92877-83
- **San Bernardino:** 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91766, 91784-86, 91798, 92252*, 92256*, 92268*, 92277-78*, 92284-86*, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92333-37, 92339-41, 92345-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-15, 92418, 92420, 92423-24, 92427, 92880
- **San Diego:** 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 91990, 92007-09, 92013-14, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, 92190-99
- **Ventura:** 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07*, 93009*, 93010-12, 93015-16, 93020-21, 93022*, 93030-36*, 93040, 93041-44*, 93060-61*, 93062-66, 93093-94, 93099

*Subscribers residing in Coachella Valley and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician). Please refer to "Your primary care Plan Physician" for details.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Post Office.

Services: Health care services or items.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of dependent status and who meets the eligibility requirements as a Subscriber.

PDF 0149-0513-01-r03 8/04

Member Service Call Center
1-800-464-4000
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
1-800-777-1370 (TTY)
7 a.m. to 7 p.m.
Seven days a week (except holidays)
members.kaiserpermanente.org

Member and Marketing Communications
August 2004
0109-0040-10-r02

PDF 0149-0513-01-r03 8/04